2007 Summary of Medical Benefits - Most Retirees Under Age 65

Group Health Cooperative (GHC)		City of Seattle Traditional Plan		City of Seattle Preventive Plan	
Standard Plan	**Deductible Plan**	**Aetna In-Network**	**Out-of-Network**	**Aetna In-Network**	**Out-of-Network**
Deductible (per calendar year)					
Does not apply	$200 per person $600 per family Except as noted, deductible applies to all services except prescriptions, preventive care visits, ambulance service and durable medical equipment.	$400 per person $1,200 per family Except as noted, deductible applies to most services. Deductible does not apply for prescriptions or when the Inpatient co-pay or emergency room co-pay applies.	$1,000 per person $3,000 per family	$100 per person $300 per family Except as noted, deductible applies to most services. Deductible does not apply for prescriptions or when the Inpatient co-pay or emergency room co-pay applies.	$450 per person $1,350 per family
Annual Out of Pocket (OOP) Maximum* (excluding deductible if applicable) Aetna Copays do not apply towards OOP					
$2,000 per person $4,000 per family	$2,000 per person $6,000 per family	$1,000 per person $3,000 per family applies to 20% coinsurance. Most costs paid at 100% after out-of-pocket maximum is paid	$2,000 per person $6,000 per family. applies to 40% coinsurance Most costs paid at 100% of recognized charge after out of pocket maximum is paid	$2,000 per person $4,000 per family Most costs paid at 100% after out-of-pocket maximum is paid	$3,000 per person $6,000 per family Most costs paid at 100% of recognized charge after out-of-pocket maximum is paid.
Maximum Lifetime Benefits Payable					
$2,000,000 lifetime maximum	$2,000,000 lifetime maximum	Combined $2,000,000 limit for Traditional and Preventive (in and out of network)			
Inpatient Copay					
$200 per admission	Does not apply	$200 copay per admission.	$200 copay per admission.	$200 copay per admission.	$200 copay per admission.
Inpatient Pre-admission Authorization					
Except for maternity or emergency admissions, must be authorized by GHC	Except for maternity or emergency admissions, must be authorized by GHC	Except for maternity or emergency admissions, your physician must contact Aetna prior to your admission		Except for maternity or emergency admissions, your physician must contact Aetna prior to your admission	
Choice of Providers					
All care and services must be approved and/or provided by GHC or GHC designated providers Members may self-refer to most GHC specialists.	All care and services must be approved and/or provided by GHC or GHC designated providers Members may self-refer to most GHC specialists.	Any Aetna contracted provider member. No primary care physician selection required. No referrals required. Aexcel specialists must be used in designated specialty areas to receive the maximum benefit.	Any licensed, qualified provider of your choice. Expenses paid based on recognized charges*. You pay the difference between recognized and billed charges.	Any Aetna contracted provider member. No primary care physician selection required. No referrals required. Aexcel specialists must be used in designated specialty areas to receive the maximum benefit.	Any licensed, qualified provider of your choice. Expenses paid based on recognized charges*. You pay the difference between recognized and billed charges.

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COVERED EXPENSES					
Acupuncture					
Paid at 100% after $15 copay Eight visits per condition per year self-referred. Additional visits with PCP referral.	Paid at 100% after $15 copay. Eight visits per condition per year self-referred. Additional visits with PCP referral.	Paid at 80% Maximum of 12 visits per calendar year for in-network and out-of-network combined. Maximum does not include acupuncture treatment for chemical dependency.	Paid at 60%	Paid at 100% after $15 copay	Paid at 60%
Ambulance Service					
Paid at 80%. GHC-initiated non-emergency transfers are paid at 100%	Paid at 80%. GHC-initiated non-emergency transfers are paid at 100%	Paid at 80% when medically necessary.		Paid at 90% when medically necessary. Non-emergency transportation must be approved in advance by Aetna.	
Chemical Dependency Treatment (alcohol/drug addiction)					
Inpatient: Paid at 100% after $200 copay Outpatient: Paid at 100% after $15 copay	Paid at 100% Outpatient: Paid at 100% after $15 co-pay.	Inpatient: Paid at 80% after $200 copay Outpatient: Paid at 80%	Inpatient: Paid at 60% after $200 copay Outpatient: Paid at 60%	Inpatient: Paid at 90% after $200 copay Outpatient: Paid at 100% after $15 copay	Inpatient: Paid at 60% after $200 copay Outpatient: Paid at 60%
Combined benefit maximum of $13,000 per 24 month period for inpatient and outpatient services	Combined benefit maximum of $13,000 per 24 month period for inpatient and outpatient services	Combined benefit maximum of $13,000 per 24 month period for in and out-of-network services		Combined benefit maximum of $13,000 per 24 month period for in-and out-of-network services	
Contraceptives					
Contraceptive drugs and devices see Prescription Drug benefit.	Contraceptive drugs and devices see Prescription Drug benefit.	See Prescription Drug benefit. IUDs and Depo Provera are covered as medical benefits.	Prescription contraceptive products are not covered. IUDs and Depo Provera are covered as medical benefits.	See Prescription Drug benefit. IUDs and Depo Provera are covered as medical benefits.	Prescription contraceptive products are not covered. IUDs and Depo Provera are covered as medical benefits.
Durable Medical Equipment					
Paid at 80%	Paid at 80%	Paid at 80% Maximum benefit of $5,000 per calendar year for in-network and out-of-network combined.	Paid at 60%	Paid at 90% Maximum benefit of $5,000 per calendar year for in-network and out-of-network combined.	Paid at 60%
Emergency Room Services					
GHC facility: Paid at 100% after $100 copay (waived if admitted) Non-GHC facility: Paid at 100% after $150 copay	GHC facility: Paid at 100% after $75 copay (waived if admitted) Non-GHC facility: Paid at 100% after $125 copay	Paid at 80% after $150 copay waived if admitted	Paid the same as in network, except if it's non-emergency use, then 60% after $150 copay (waived if admitted).	Paid at 90% after $150 copay waived if admitted	Paid the same as in network, except if it's non-emergency use, then 60% after $150 copay (waived if admitted).
Home Health Care					
Paid at 100% when authorized	Paid at 100% when authorized	Paid at 80% Maximum benefit of 130 visits per calendar year for in-network and out-of-network combined.	Paid at 60%	Paid at 90% Maximum benefit of 130 visits per calendar year for in-network and out-of-network combined.	Paid at 60%

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Hospital Inpatient					
Paid at 100% after $200 copay per admission	Paid at 100%	Paid at 80% after $200 copay Physician services paid at 70% if Aexcel specialist is not used in specialty areas	Paid at 60% after $200 copay	Paid at 90% after $200 copay. Physician services paid at 80% if Aexcel specialist is not used in specialty areas	Paid at 60% after $200 copay
Hospital Outpatient					
Paid at 100% after $15 copay for most visits	Paid at 100% after $15 copay for most visits	Paid at 80% after satisfaction of deductible	Paid at 60% after satisfaction of deductible	Paid at 90% after satisfaction of deductible. .	Paid at 60% after satisfaction of deductible
Hospice					
Paid at 100% when authorized	Paid at 100% when authorized	Paid at 80% Lifetime maximum of 6 months or $10,000, whichever is greater. 14-day inpatient limit. 120-hour outpatient limit.	Paid at 60%	Paid at 90% Maximum of 6 months for inpatient and outpatient combined. Additional six months available if authorized	Not covered.
Maternity Care (delivery & related hospital)					
Paid at 100% after $200 copay	Paid at 100%	Paid at 80% after $200 copay	Paid at 60% after $200 copay	Paid at 90% after $200 copay	Paid at 60% after $200 copay
Maternity Care (prenatal and postpartum)					
Paid at 100% after $15 copay	Paid at 100% after $15 copay	Paid at 80%	Paid at 60%	First pre-natal visit paid at 100% after $15 copay. All other charges paid as part of the negotiated fee for entire pregnancy.	Paid at 60%
Mental Health Care (inpatient)					
Paid at 80% after $200 copay	Paid at 80%	Paid at 80% after $200 copay	Paid at 60% after $200 copay	Paid at 90% after $200 copay	Paid at 60% after $200 copay
Mental Health Care (outpatient)					
Paid at 100% after a $15 copay per individual, family or couple session or $7.50 copay per group therapy visit. Copays do not apply to the out-of-pocket maximum	Paid at 100% after $15 copay per individual, family or couple session or $7.50 copay per group therapy visit. Copays apply to the out-of-pocket maximum	Paid at 80% Coinsurance does not apply to the annual out-of-pocket maximum		Paid at 100% after $15 copay.	Paid at 60% after deductible Coinsurance applies to the annual out-of-pocket maximum.
Neurodevelopmental Therapy (for children 6 and under)					
Covered under Rehabilitation benefit.	Covered under Rehabilitation benefit.	Outpatient: Paid at 80%. Maximum of $2,000 per calendar year. Coinsurance does not apply to the out-of-pocket maximum.	Outpatient: Paid at 60% .	Outpatient: Paid at 100% after $15 copay. Maximum of $3,000 per calendar year for in-network and out-of-network combined.	Outpatient: Paid at 60% Coinsurance applies to the annual out-of-pocket maximum.

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Standard Plan	**Deductible Plan**	**Aetna In-Network**	**Out-of-Network**	**Aetna In-Network**	**Out-of-Network**
Physician Office Visit					
Paid at 100% after $15 copay for most visits	Paid at 100% after $15 copay for most visits	Paid at 80%	Paid at 60%	Paid at 100% after $15 copay per visit (copay waived for preventive care visits)	Paid at 60%
Prescription Drugs (retail)					
For a 30 day supply: **Generic**: $15 copay **Brand:** $30 copay Contraceptive drugs and devices are covered subject to the pharmacy copay. Copays do not apply to the annual out-of-pocket maximum.	For a 30-day supply: **Generic**: $15 copay **Brand:** $30 copay Contraceptive drugs and devices are covered subject to the pharmacy copay. Copays do not apply to the annual out-of-pocket maximum.	For a 34-day supply: **Generic**: 30% coinsurance. Some generic maintenance drugs dispensed as greater of 34-day supply or 100 units. **Brand**: 40% coinsurance The minimum coinsurance is $10, or actual cost of the drug if less. The maximum is $100 per drug. Many contraceptive products are covered. IUDs and Depo Provera are covered under the medical plan benefit. Coinsurance applies to the prescription $1,500 out-of-pocket annual maximum per person.	Not covered	For a 31-day supply: **Generic**: 30% coinsurance **Brand:** 40% coinsurance The minimum coinsurance is $10, or actual cost of the drug if less. The maximum is $100 per drug. Many contraceptive products are covered. IUDs and Depo Provera are covered under the medical plan benefit. Coinsurance applies to the prescription $1,500 out-of-pocket annual maximum per person.	Not covered
Prescription Drugs (mail order)					
For a 90 day supply: **Generic**: $45 copay **Brand:** $90 copay Contraceptive drugs and devices are covered subject to the pharmacy copay. Copays do not apply to the annual out-of-pocket maximum.	For a 90 day supply: **Generic**: $30 copay **Brand:** $60 copay Contraceptive drugs and devices are covered subject to the pharmacy copay. Copays do not apply to the annual out-of-pocket maximum.	For a 90-day supply: **Generic**: 30% coinsurance **Brand**: 40% coinsurance **The minimum coinsurance is $20 or double the cost of the drug if less. The maximum is $200 per drug.**	Not Covered	For a 90-day supply: **Generic**: 30% coinsurance **Brand:** 40% coinsurance **The minimum coinsurance is $20 or double the cost of the drug if less. The maximum is $200 per drug.**	Not Covered
Preventive Care					
Paid at 100% after $15 copay for preventive care visits, most immunizations, hearing exams, eye exams and mammograms.	Paid at 100% after $15 copay for preventive care visits, most immunizations, hearing exams, eye exams and mammograms. . Hearing exams are subject to deductible	Mammograms paid at 80%. No other preventive services are covered.	Mammograms paid at 60%	Paid at 100% (copay waived) for routine physical exams, well child care, immunizations, well woman care and mammograms.	Paid at 60% for well woman care and mammograms. No other preventive services covered.

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Rehabilitation Services (inpatient)					
Paid at 100% after $200 copay per admission Maximum of 60 days per calendar year.	Paid at 100% Maximum of 60 days per calendar year.	Paid at 80% after $200 copay	Paid at 60% after $200 copay Maximum of $50,000 per condition for in-network and out-of-network combined.	Paid at 90% after $200 copay	Paid at 60% after $200 copay Maximum of 120 days per calendar year for in-network and out-of-network combined.
Rehabilitation Services (outpatient)					
Paid at 100% after $15 copay Maximum of 60 visits per calendar year (combined with other therapy benefits)	Paid at 100% after $15 copay Maximum of 60 visits per calendar year (combined with other therapy benefits)	Paid at 80% Coinsurance does not apply to the annual out-of-pocket maximum. Benefit includes physical/massage, speech, and occupational therapy. Maximum calendar year benefit of $2,000 for in-network and out-of-network combined.	Paid at 60%	Paid at 100% after $15 copay Benefit includes physical/massage, speech, occupational and cardiac/pulmonary therapy. Maximum of 20 visits for each of the above listed benefits per calendar year for in-network and out-of-network combined.	Paid at 60%
Skilled Nursing Facility					
Paid at 100%; 60 day maximum per calendar year.	Paid at 100%; 60 day maximum per calendar year.	Paid at 80% after $200 copay Maximum of 90 days per calendar year for in-network and out-of-network combined.	Paid at 60% after $200 copay	Paid at 90% after $200 copay Maximum of 120 days per calendar year for in-network and out-of-network combined.	Paid at 60% after $200 copay
Smoking Cessation					
Paid at 100% for individual/group sessions. Nicotine replacement therapy included in Prescription Drugs benefit.	Paid at 100% for individual/group sessions. Nicotine replacement therapy included in Prescription Drugs benefit.	Lifetime maximum of one 90-day supply of smoking cessation aids or drugs. See Prescription Drugs; retail.	Not covered	Not covered	
Spinal Manipulations					
Paid at 100% after $15 copay. Self-referral to GHC designated providers. Must meet GHC protocol. Maximum of 10 visits per calendar year.	Paid at 100% after $15 copay. Self-referral to GHC designated providers. Must meet GHC protocol. Maximum of 10 visits per calendar year.	Paid at 80% Maximum of 10 visits per calendar year for in-network and out-of-network combined.	Paid at 60%	Paid at 100% after $15 copay. Maximum of 20 visits per calendar year for in-network and out-of-network combined.	Paid at 60%
Sterilization Procedures					
Not covered	Not covered	Inpatient: Paid at 80% after $200 copay Outpatient: Paid at 80%.	Inpatient: Paid at 60% after $200 copay Outpatient: Paid at 60%	Inpatient: Paid at 90% after $200 copay Outpatient Surgery: Paid at 90%	Inpatient: Paid at 60% after $200 copay Outpatient Surgery: Paid at 60%
Temporomandibular Joint (TMJ) Services					
Inpatient: Paid at 100% after $200 copay per admission	Inpatient: Paid at 100%	Not covered		Not covered	
Outpatient: Paid at 100% after $15 copay Maximum benefit of $1,000 per calendar year/$5,000 lifetime for inpatient and outpatient combined.	Outpatient: Paid at 100% after $15 copay Maximum benefit of $1,000 per calendar year/$5,000 lifetime for inpatient and outpatient combined.				

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Standard Plan	**Deductible Plan**	**Aetna In-Network**	**Out-of-Network**	**Aetna In-Network**	**Out-of-Network**
Tooth Injury due to accident					
Not covered	Not covered	Inpatient: Paid at 80% after $200 copay Outpatient: Paid at 80% Services of dentist or denturist covered based on recognized charges* up to 12 months from injury date to a maximum of $600 per occurrence. Physician and hospital benefits provided if inpatient care needed.	Inpatient: Paid at 60% after $200 copay Outpatient: Paid at 60%	Inpatient: Paid at 90% after $200 copay Outpatient: Paid at 100% after $15 copay for office visit. Other charges paid at 90% after satisfaction of deductible. Services of dentist or denturist covered based on recognized charges* up to 12 months from injury date. Physician and hospital benefits provided if inpatient care needed.	Inpatient: Paid at 60% after $200 copay Outpatient: Paid at 60%
Travel Outside of Country					
Emergency: Paid at 100% after $150 deductible Non-emergency: Not covered. Member must notify GHC within 24 hours of inpatient admission.	Emergency: Paid at 100% after $125 deductible Non-emergency: Not covered Member must notify GHC within 24 hours of inpatient admission	Not applicable	Paid at 80% after applicable office, emergency room or hospital copay for an emergency. Paid at 60% after applicable copay for non-emergency.	Not applicable	Paid at 100% after applicable office, emergency room or hospital copay. Paid at 60% after applicable copay for non-emergency.
Vision Hardware					
Exam: Paid at 100% after $15 copay at GHC. Hardware: Not covered.	Exam: Paid at 100% after $15 copay at GHC. Hardware: Not covered.	Exam: Paid at 100%. Hardware: Two lenses per calendar year; $20-$40 per lens. Additional coverage for special eye conditions. Frames: $30 every other year.		Not covered.	
X-ray and Lab Tests					
Paid at 100%	Paid at 100%	Paid at 80%	Paid at 60%	Paid at 90%. (Covered at 100% when associated with a routine physical exam)	Paid at 60%

* Applies to Aetna - Recognized charges are the lower of the provider's usual charge for performing a service, and the charge Aetna determines to be the recognized charge percentage in the geographic area where the service is provided.

^ Applies to Aetna – Aexcel network, a specialty network of doctors in the 12 specialty areas. The coinsurance level will drop 10% for non-Aexcel doctors in the six specialty areas (coinsurance applies to in-network, out-of-pocket maximum).

This summary is intended to assist you in decision making. Details of covered benefit limitations and exclusions are provided in your benefit booklet. This summary is not a contract...